

**REVIEW OF THE KENTUCKY CHILDREN'S
HEALTH INSURANCE PROGRAM**

ADOPTED BY PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE

**PROGRAM REVIEW & INVESTIGATIONS COMMITTEE
STAFF REPORT**

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LEGISLATIVE RESEARCH COMMISSION

Frankfort, Kentucky

Committee for Program Review and Investigations

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Program Evaluation: Kentucky Children's Health Insurance Program

Research Staff: Tom Hewlett

Scope and Purpose

Responding to concerns raised by legislators about the KCHIP program, the Program Review and Investigations Committee approved a review of KCHIP at its January 14, 1999 meeting. Issues specifically identified for review included: delayed implementation, marketing/outreach, potential loss of federal funds, understaffing, and public health department funding.

Methodology

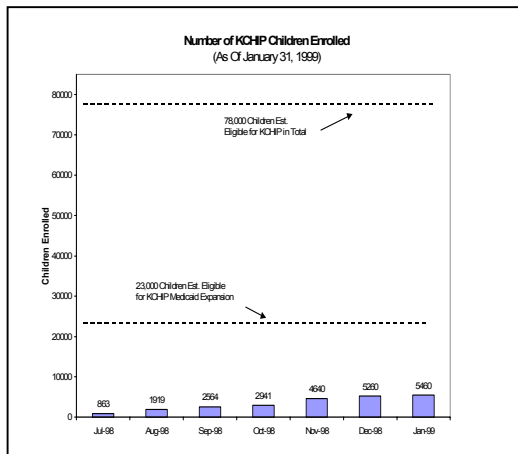
The primary focus was to determine the progress of the KCHIP program. Pertinent state and federal legislation was reviewed and HCFA officials were interviewed. Interviews with state officials included: the Secretary of the Cabinet for Health Services, the Commissioner and Deputy Commissioner of the Department for Medicaid Services, and other staff members of CHS. Other states with CHIP programs were surveyed, in order to develop comparative measures for KCHIP. More in-depth interviews were conducted with officials in states identified as high performance states to identify lessons they

had learned from their implementation efforts. Financial data from local health departments was analyzed to gain an understanding of the impact of managed care organizations on local health departments.

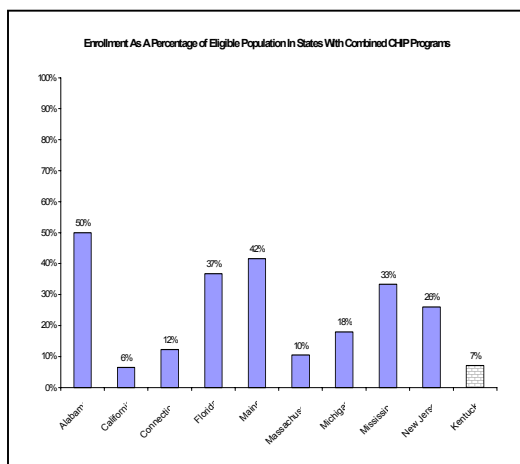
Chapter II Background

Congress created the CHIP program in 1997, authorizing \$48 billion over ten years, to enable states to extend health coverage to uninsured children. Kentucky's Cabinet for Health Services chose to create CHIP by blending a Medicaid expansion and a separate insurance program for children to provide coverage for children with family incomes up to 200 percent of the federal poverty level. Kentucky's Medicaid expansion began on July 1, 1998. Kentucky's plan for a separate insurance portion of the Children's Health Insurance Program (CHIP) is scheduled for implementation in July 1999.

Chapter III Legislative Concerns Partially Met by KCHIP Strategy



Even though the state Cabinet for Health Services is implementing Kentucky's CHIP (KCHIP) within timeframes mandated by the Legislature, the Cabinet's approach does not address all the concerns the General nrolling children for less than a year, the implementation strategy has already encountered a number of difficulties. Kentucky is lagging KCHIP and delays in developing a KCHIP administrative structure have contributed to a lower than average enrollment.



lth departments. The managed care nature of APOs also raises concerns about potential duplication with existing or planned Medicaid managed care partnerships, and raises concerns about the cost effectiveness of the administrative structure for KCHIP. We are also concerned that proposed provider networks may not be able to provide equal care to all children. Also, several children in a family may participate in different programs or move repeatedly from one to another.

Assembly raised about the program. The Cabinet's program enrollment goals do not reflect the critical needs highlighted by the legislation.

Also, the planned implementation will most likely not maximize federal funding.

Chapter IV KCHIP Implementation Problems

Even though KCHIP has been actively e

behind many other states in enrolling children in Children's Health Insurance Programs. Delays in the federal approval of

Questions have arisen concerning the exclusion of children of state employees whose income would otherwise qualify them for KCHIP.

Chapter V Additional Concerns

Concerns have also arisen over the administrative organizations CHS plans to use in implementing KCHIP. CHS plans to use accountable pediatric organizations (APO), a concept similar to those of other managed care organizations. It is doubtful that APOs will improve the financial outlook for local hea

Recommendation 1: Develop a plan for enrolling children by September 1, 1999.

In keeping with the critical need of providing health insurance to children, CHS should develop and submit to the legislature a plan for enrolling as many children as possible in KCHIP by September 1, 1999.

Recommendation 2: Provide quarterly reports on KCHIP program status.

Based on the limited enrollment to date, provisions in 1998 legislation, and the lack of outreach efforts to date, we recommend that CHS provide quarterly reports to the legislature beginning in May 1999, detailing the following information:

- The number of children enrolled in KCHIP.
- Total funds spent on KCHIP, to include the amount of federal funds spent to date by federal fiscal year.
- Efforts the Cabinet has undertaken to increase public knowledge of KCHIP and effectively market the program to the target population.

Recommendation 3: Report on the eligibility of state employees' children.

Based upon HCFA's decision that Kentucky state employees' children are not eligible for inclusion in the separate insurance aspect of the KCHIP program, we recommend that CHS provide a report on their contingency plan to provide coverage to children of state employees who would otherwise be eligible for the KCHIP program.

Recommendation 4: Report on new roles and funding for public health departments.

Existing groups reviewing the financial status of health departments should develop a plan, identifying new roles and funding sources for health departments. This plan should be submitted to the legislature for review before the July 1, 1999 start-up date for the APO networks.

Recommendation 5: Develop a plan for monitoring and assessing the APO networks.

CHS should develop and submit to the legislature a plan for monitoring the activities of the APO networks and assessing performance based upon quantifiable performance measures and health outcome measures contained in the RFP. Assessment of APO performance should then be carried out in accordance with the plan and reported to the legislature annually.

FOREWORD

In January 1999, the Program Review and Investigations Committee directed staff to review the implementation of the Kentucky Children's Health Insurance Program. This report was adopted by the Committee on April 8, 1999, and submitted to the Legislative Research Commission.

This report is the result of dedicated time and effort by the Program Review staff, Committee Staff Associates; Melissa Biggs, Deborah Crocker, Joe Pinczewski-Lee, and Erica Warren, as well as secretary Susan Spoonamore. Our appreciation is also expressed to the Secretary of the Cabinet for Health Services, the Commissioner and staff of the Department for Medicaid Services, and all other persons interviewed for this study.

Bobby Sherman
Director

Frankfort, KY
April, 1999

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CHAPTER I

BACKGROUND

Responding to declines in private insurance coverage for children, the federal government created a new Children's Health Insurance Program (CHIP). The bipartisan Balanced Budget Act of 1997, under Title XXI of the Social Security Act, authorized \$48 billion over ten years to enable states to extend health care coverage to uninsured children by 1) expanding Medicaid coverage to additional children, 2) creating a separate insurance program for children, or (3) some combination of the first two approaches. Kentucky opted for the combined approach and began enrolling children under its Medicaid expansion in July of 1998. Kentucky's plan for the separate insurance portion of the program was approved November 25, 1998 and is scheduled for implementation in July 1999.

Declines in Private Insurance Put Children at Risk

Nationally, from 1989 to 1995 the percentage of children with private health insurance dropped from 74 percent to 66 percent. By 1996, it was estimated that 10.6 million children were uninsured. Of these, an estimated 4.7 million met Medicaid eligibility criteria, but were not enrolled. The majority of uninsured children live in families of the working poor. This is due, in large part, to a growing corporate trend of reducing contributions to family insurance coverage. According to the U. S. General Accounting Office, as health insurance premiums reached 10 percent of employers' payroll costs, many employers were forced to reconsider the amount of employee insurance they would support. In 1993, almost one-quarter of the workforce could not get family coverage at work. Over 18 million workers were employed by firms that did not sponsor coverage at all, and more than 5 million worked for firms that sponsored coverage for the individual but not family members.

Federal Government Takes Action to Insure Children

Responding to concerns about the growing problem of uninsured children, legislation authorizing CHIP was included in Title XXI of the Social Security Act and signed into legislation on August 5, 1997, as part of the Balanced Budget Act of 1997. The CHIP legislation targeted uninsured children with family incomes too high for Medicaid, but too low to afford private family coverage. Oversight of the CHIP program is shared between two agencies within the U.S. Department for Health and Human Services: the Health Care Financing Administration (HCFA), and the Health Resources and Services Administration (HRSA).

Federal Funding Provides Enhanced Match Rate

Made available for use by state CHIP programs on October 1, 1997, the federal funds to states are specified in statute and are allocated to states according to a statutory formula based on the number of uninsured, low-income children and a geographic cost factor. Funding is contingent upon federal approval of a state plan outlining the approach the state will take in its CHIP program. It is important to note that funding is available through an enhanced match of state expenditures; payment may only be made based on actual expenditures for a given period; and payment is not based on the state's allotment. Kentucky's usual Medicaid matching rate is 70/30, with the federal government matching 70 cents for every 30 cents the state spends on Medicaid. The enhanced match rate under CHIP means that the federal government will absorb 79 cents of every dollar spent on CHIP, leaving Kentucky to pay only 21 cents on the dollar for expenditures on the Kentucky CHIP program.

States may also claim up to 10 percent of their total expenditures for administration, outreach and direct purchase of health services. Federal officials have stressed the need for effective outreach programs to enroll children in CHIP, noting that this will be one of the components Congress will consider when reviewing the effectiveness of the CHIP program. Preventive services have also been stressed, and the provision that no deductibles, coinsurance or other cost-sharing may be imposed for preventive services.

Kentucky's federal CHIP allotment for FY 1998 is \$50.2 million. Should Kentucky expend all of the federal allotment, the state's match for FY 1998 would be \$13.9 million, for a total amount of \$64.1 million. If Kentucky does not use all of its CHIP funds in any given year, the remaining unused funds may be accessed in the two succeeding federal fiscal years. Should the federal allotment be exceeded in any given year, a state that elects to put its CHIP funds into a separate state insurance program cannot receive additional federal funds for the cost of covering children. States using the Medicaid expansion may continue to collect a federal match at the state's regular matching rate after exceeding the allotment.

Kentucky's CHIP Legislation

In response to the federal CHIP legislation, the Kentucky General Assembly passed Senate Bill 128 on March 31, 1998. The bill was passed with an emergency clause and took effect upon its approval by the Governor on April 2, 1998. The legislation directed the Cabinet for Human Resources (now Cabinet for Health Services) to prepare a state child health plan for submission to the U. S. Department of Health and Human Services, "within such time as will permit the state to receive the maximum amounts of federal matching funds available under Title XXI." The legislation also directed the Cabinet to establish eligibility criteria for children covered by CHIP, the schedule of benefits to be covered by CHIP, premium contributions per family based upon a sliding scale relating to family income, the level of copayments for services provided, and the criteria for health services providers and insurers wishing to provide CHIP coverage. The legislation also stipulated that the Cabinet would assure that a CHIP program would be available to all eligible children in all regions of the state within 12 months of the federal approval of the state's Title XXI plan.

Mirroring federal concerns about preventive services, the Kentucky General Assembly noted that measures not taken now to provide care for uninsured children will result in higher human and financial costs, as a result of the development of more severe conditions. In keeping with the federal legislation, SB 128 directs that the Kentucky CHIP (KCHIP) program include a system of outreach and referral for children who may be eligible for the program. The statute prohibits copayments, deductibles, coinsurance, or premium payments for the preventive health services provided by the program.

The Cabinet for Health Services (CHS) elected to implement the KCHIP program through a combined approach, using a limited Medicaid expansion and a separate state insurance program. The Medicaid expansion provides full coverage to children 14 through 18 years of age whose family income is below 100% of the federal poverty level (FPL). An estimated 23,000 children were eligible for this Medicaid expansion, which took effect July 1, 1998.

The separate insurance portion of the KCHIP program will provide coverage for children from birth through 18 years of age whose family income is between 100% FPL and 200% FPL and who are not already eligible for Medicaid (see Figure 1). Fifty-five thousand children are estimated to be eligible for this portion of the KCHIP program. (Note: In Kentucky, Medicaid is available for children up to 1 year old with family incomes up to 185 percent FPL and children up to 6 years old with family incomes up to 133 percent FPL.) CHS plans to implement the separate insurance portion of the KCHIP program through specialized managed care providers, which the Cabinet refers to as “accountable pediatric organizations” (APOs).

Figure 1

Federal Poverty Level Guidelines

	100% FPL	200% FPL
Family Size	Yearly Income	Yearly Income
1	\$8,050	\$16,100
2	\$10,850	\$21,700
3	\$13,650	\$27,300
4	\$16,450	\$32,900
5	\$19,250	\$38,500
6	\$22,050	\$44,100
7	\$24,850	\$49,700
8	\$27,650	\$55,300

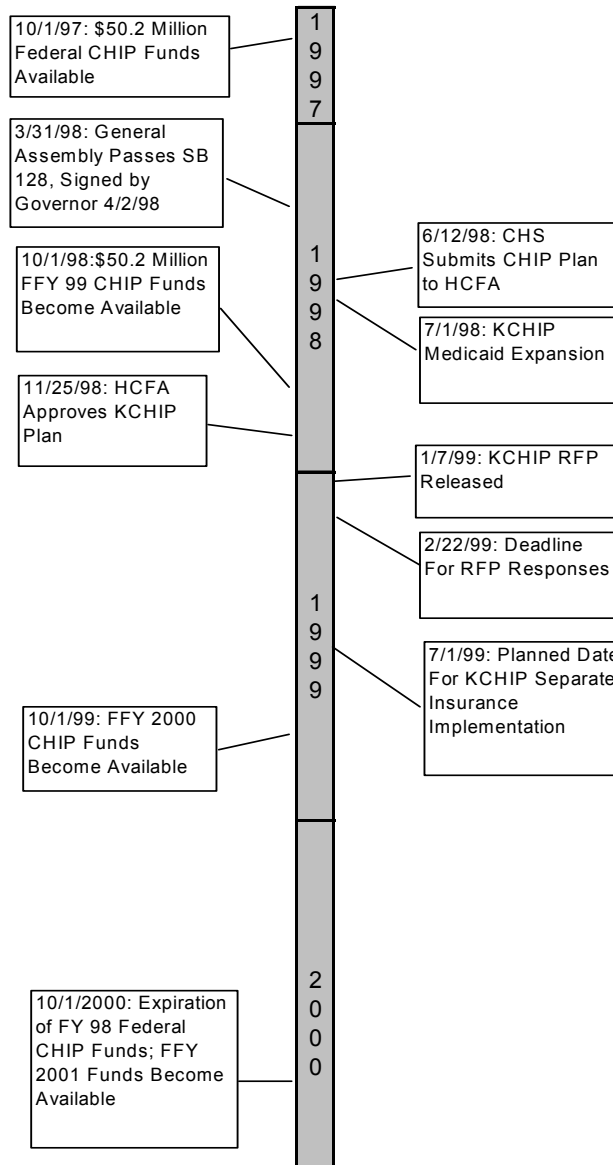
CHS issued a request for proposals (RFP) on January 7, 1999, to solicit bids from potential APOs. As of the February 22, 1999 deadline for responses, CHS had received only two bids; one from University Health Care, Inc., in Louisville, and one from CHA HMO, Inc., in Lexington. University Health Care proposed serving the western part of the state and CHA proposed serving the eastern part of the state. CHS officials said they could not disclose whether the two bids covered overlapping territories, citing the need to maintain confidentiality during the bidding process. CHS officials did tell us, however, that the two bids would provide coverage for the entire state.

An interagency committee will review the two proposals, under the direction of the Department for Medicaid Services, and negotiations will begin with bidders that meet all requirements. Bidders will be required to provide outreach services, preventive and well child care, as well as the more traditional health care services associated with meeting the health care needs of young people. In exchange for their services, contractors will receive a predetermined amount per enrollee, called a capitated rate. This approach is similar to that of the Medicaid managed care regions already in place in Kentucky.

Figure 2 reflects the KCHIP implementation timeline from October 1, 1997, when federal funds first became available for CHIP, through October 1, 2000, when federal fiscal year 1998 funds for CHIP expire.

Figure 2

KCHIP Implementation Timeline



KCHIP Implementation Timeline

Source: Compiled by Program Review Staff based upon data provided by CHS

CHAPTER II

LEGISLATIVE CONCERNS PARTIALLY MET BY KCHIP STRATEGY

The KCHIP implementation approach selected by the Cabinet for Health Services (CHS) does not meet all concerns the General Assembly raised about the program. SB 128 specified three basic concerns:

- The program should be implemented promptly. The legislation required that implementation occur no more than one year after Kentucky's program received approval from the federal government.
- The legislation also recognized that providing health insurance for children is a critical need, and found that children should have access to health care programs, even if their parents are unable to afford care.
- Finally, SB 128, as well as House Bill 321, directed that CHS should maximize all available federal funding.

Although CHS plans to implement the KCHIP program within the timeframes mandated by the legislation, other crucial concerns have not been sufficiently addressed. Program enrollment goals do not reflect the critical needs highlighted by the legislation, nor will the planned implementation maximize federal funding.

KCHIP Program Scheduled to be Within Legislative Time Limits

Senate Bill 128, Section 3, mandated that the CHS shall assure that a KCHIP program is available to ALL ELIGIBLE children in ALL REGIONS of the state within 12 months of federal approval of the state's CHIP plan. CHS began enrolling a limited number of KCHIP-eligible children in the Medicaid expansion portion of the KCHIP program on July 1, 1998, before the state plan had been approved by HCFA. The Medicaid expansion, however, represents only 27 percent of the children eligible for KCHIP. The KCHIP timeline calls for beginning statewide enrollment of the separate insurance portion for the rest of the eligible children in July 1999, well before the statutory deadline. While this meets statutory requirements, Program Review Staff are

concerned that although available across the state, the enrollment goals of the KCHIP program indicate that it will require several years before the majority of eligible children are enrolled.

Less than Half of Eligible Children Planned for Enrollment in Three Years

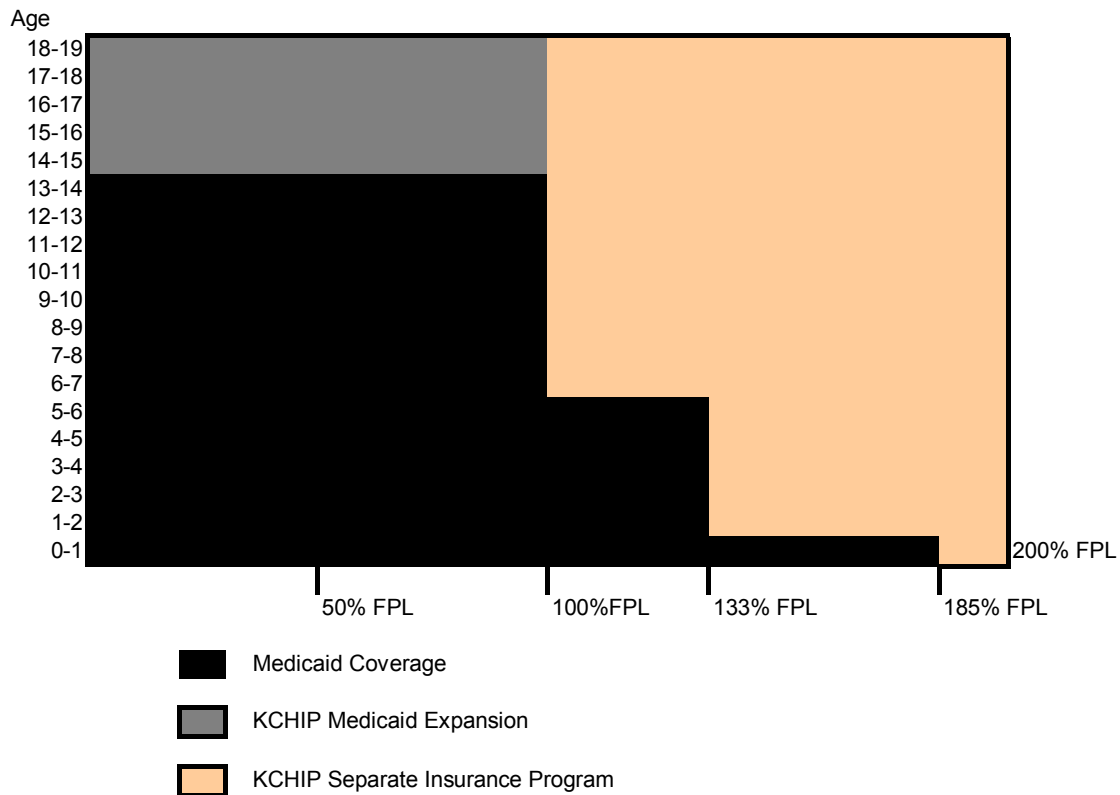
The approach CHS selected for the implementation of the KCHIP program reflects the enrollment goals CHS established. While the KCHIP implementation plan meets the legislatively mandated schedule, it delays the availability of health insurance for uninsured children. On July 1, 1998, CHS began enrolling children through a Medicaid expansion for those aged 14 through 18 whose family income was not above 100 percent of the federal poverty level (\$13,650 for a family of three). The KCHIP separate insurance program, which will provide insurance for 70 percent of the children eligible for KCHIP, will not begin until July 1, 1999.

In addition to the schedule requirements imposed by the General Assembly, Senate Bill 128 also recognized the critical need of providing health insurance for children. In SB 128, the General Assembly noted that failure to provide care for uninsured children will result in higher human and financial costs from the development of more severe conditions and declared that children should have access to health care programs even if they or their parents are unable to afford care. The bill further declared an emergency, making the bill effective upon its approval by the Governor.

Enrollment goals established for the KCHIP program by CHS do not reflect the legislative concerns, which stress the critical need of enrolling children. CHS has established a goal of enrolling 5,000 in the first year of the program, 6 percent of those eligible for KCHIP. The Cabinet's goal for the second year of the program is for an enrollment of 23,750 children, 30 percent of the eligible population. By the end of the third year the Cabinet's goals call for an enrollment of 37,500, or 48 percent of the eligible children in the state. The following Figure (Figure 3) indicates the relative proportion of children to be covered by Medicaid, the KCHIP Medicaid expansion and the KCHIP separate insurance program.

Figure 3

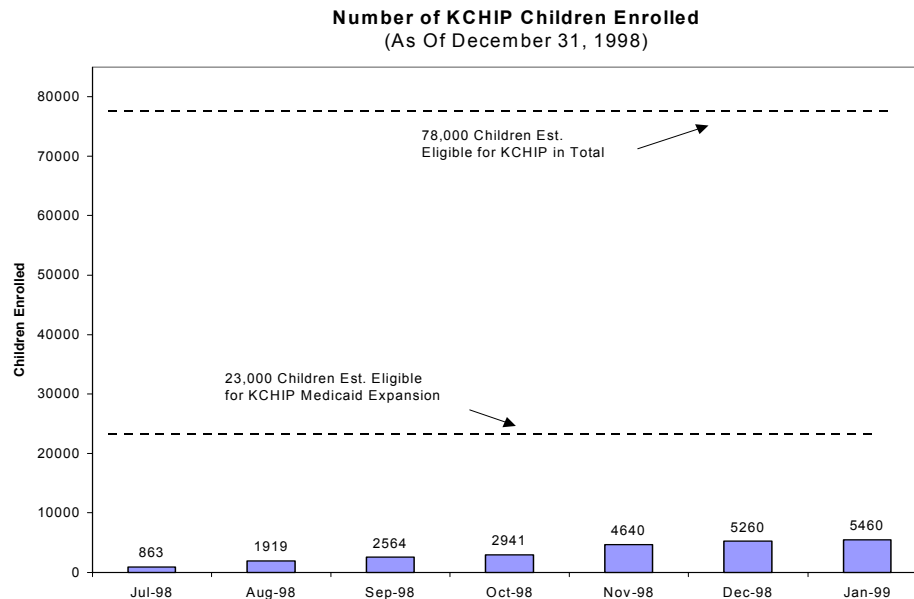
Medicaid and KCHIP Age and Income Limits



Source: Compiled by Program Review Staff from data provided by CHS

As of January 31, 1999, the KCHIP Medicaid expansion had enrolled approximately 5,460 children, approximately 24 percent of the children estimated to be eligible for the Medicaid expansion portion of KCHIP. When compared to the estimated population of children eligible for KCHIP, however, they represent only 7 percent of the estimated 78,000 Kentucky children eligible for KCHIP. Figure 4 illustrates KCHIP enrollment through January 31, 1999.

Figure 4



Number of KCHIP Children Enrolled

Source: Compiled by Program Review Staff based upon information provided by CHS.

(Note: the increase from Dec. 1998 to January 1999 actually represents an increase of roughly 700 children. During this same time period, 500 foster care children, erroneously enrolled in KCHIP, were removed from the rolls. Although the net increase was only 200 children, 700 new children were added to the KCHIP program.)

Kentucky's combined approach to CHIP, offering both a Medicaid expansion and a separate insurance program, is not unique. Ten other states have also adopted a combination program. Appendix A highlights the approaches adopted by other states. Differences between the KCHIP Medicaid expansion and the planned separate insurance program are highlighted in Figure 5.

Figure 5

COMPARISION OF KCHIP MEDICAID EXPANSION

AND PLANNED SEPARATE INSURANCE PROGRAM

	Separate Insurance Program	Medicaid Expansion
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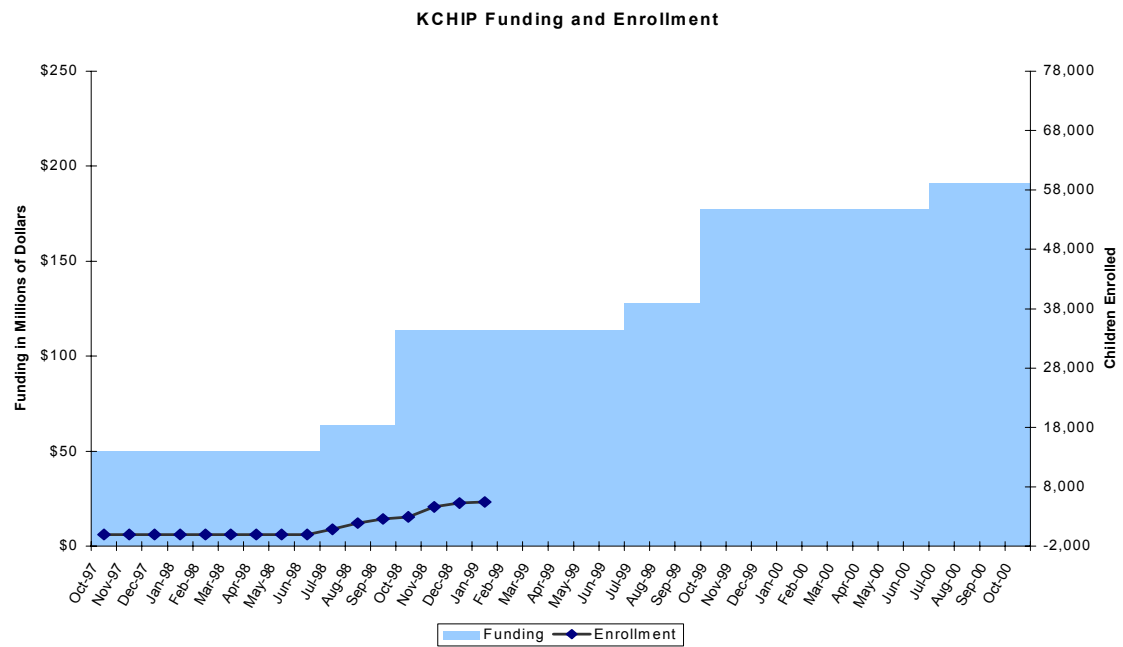
Are children of state employees covered?	No, exception being requested.	Yes
If federal CHIP funding is surpassed	No additional funds promised.	Federal funding continues at standard Medicaid Matching rate of 70/30.
Administrative Structure	Not yet developed, providers not selected (As of 3/1/99). Potential for duplicate structure with Medicaid managed care partnerships.	In Place.
Implementation	Enrollment not planned to begin until 7/1/99.	Enrollment began 7/1/98.
Eligible Children	55,000	23,000

Planned Implementation Will Not Maximize Federal Funding

SB 128, Section 3 (1) also requires that CHS submit its state child health plan within such time as will permit the state to receive “the maximum amounts of federal matching funds available. House Bill 321 also requires CHS to maximize federal funds. The approach selected for the implementation of KCHIP, however, limits the availability of federal matching funds. Federal matching funds for KCHIP may only be drawn upon as a match for state expenditures for administrative and benefit costs. By limiting KCHIP enrollment during the early years of the program, CHS has limited the availability of federal funds.

As shown in Figure 6, federal matching funds for CHIP first became available to the states on October 1, 1997. Funding for federal fiscal year 1998 and 1999 is currently available, a total of approximately \$100 million for Kentucky. Additionally, \$13.9 million in state funds are available to the program. As of January 31, 1999, however, CHS had spent approximately \$2.8 million on KCHIP benefits, or 2.5 percent of the funding currently available. On July 1, 1999, when the separate insurance portion of the KCHIP program is scheduled for implementation, another \$13.9 million in state funding becomes available. Federal fiscal year 2000 funds become available in October 1999, shortly after the implementation of the separate insurance portion of the KCHIP program begins.

Figure 6



Source: Compiled by Program Review Staff Based Upon Data Provided by CHS

The federal matching funds for KCHIP have a three-year limit on their availability and, as noted earlier, may only be drawn upon as a match for state expenditures for benefits or administrative costs actually incurred. After three years the federal government has the option of withdrawing the unused funding and reallocating the funds to states that need additional funding for their CHIP programs. Availability of the FFY 98 CHIP funds will expire on October 1, 2000. While Kentucky may not have used all of the available federal funding if it had adopted a different approach to CHIP (a number of states that have taken an aggressive approach to enrolling children in their CHIP programs have indicated that they doubt they will use all of their first year federal funds), the approach selected virtually guarantees that Kentucky will not make the maximum possible use of those funds. Federal funds that could have provided health insurance benefits to children are at risk.

Recommendation 1: Develop a plan for enrolling children by September 1, 1999.

In keeping with the critical need of providing health insurance to children, CHS should develop and submit to the legislature a plan to enroll as many children as possible in KCHIP by September 1, 1999.

CHAPTER III

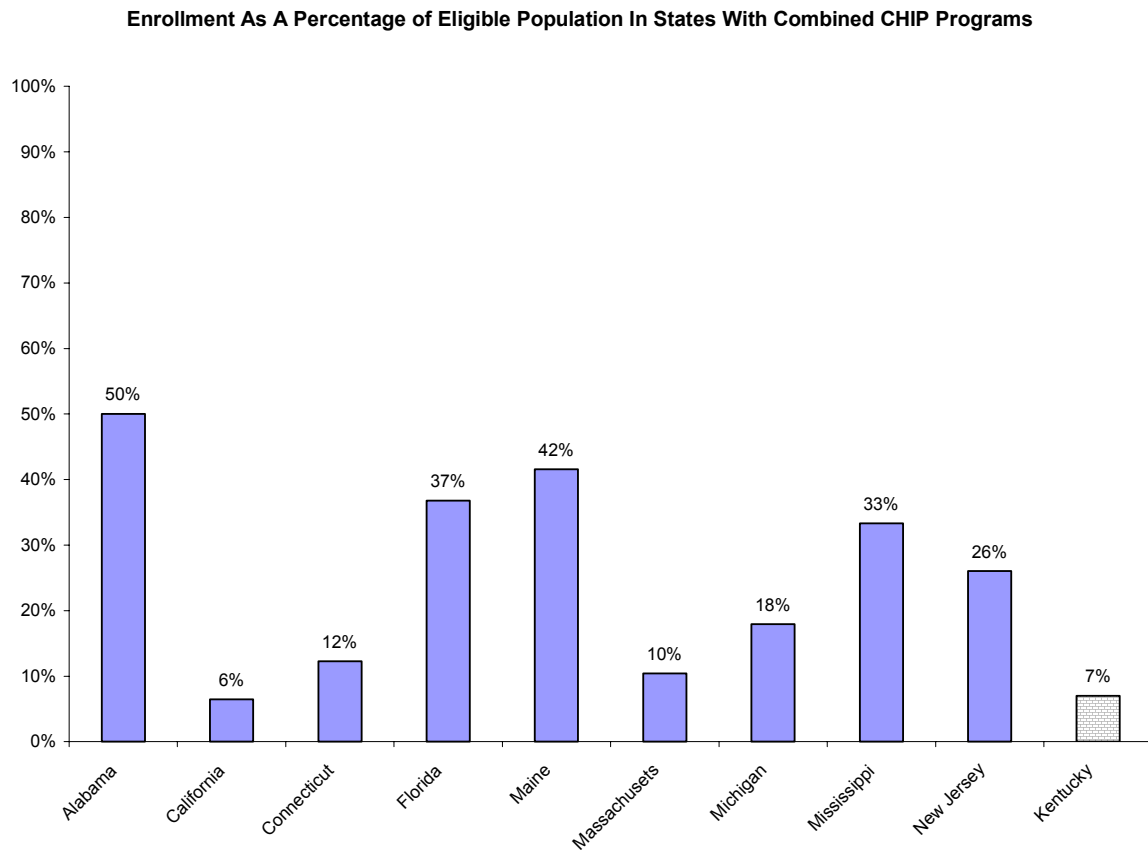
KCHIP IMPLEMENTATION PROBLEMS

Although the KCHIP program has been actively enrolling children for less than a year, the implementation strategy has already encountered a number of difficulties. Kentucky lags behind many other states in enrolling children. Delays in the federal approval for Kentucky's CHIP program and delays in developing a KCHIP administrative structure have contributed to the lower than average enrollment. Additionally, the exclusion of the children of state employees whose income would otherwise qualify them for KCHIP has caused concern. Furthermore, the Cabinet is being forced to delay outreach and enrollment activities until all aspects of its implementation strategy are ready.

Kentucky Enrollment Lags Behind That of Most Other States

Program Review Staff compared the progress made by CHIP programs in other states to Kentucky's efforts and found that Kentucky has not enrolled as many children as a number of other states. Of the 37 states that responded to a staff survey, nine states had adopted a combined Medicaid expansion/separate insurance program similar to Kentucky's (see Figure 7 and Appendix A). Staff found that enrollment in those states currently averages approximately 26 percent of the eligible population, or about 26,182 children (see Appendix B). As noted earlier, the 5,460 children enrolled in Kentucky as of January 31, 1999 represent approximately 7 percent of those eligible for the KCHIP program.

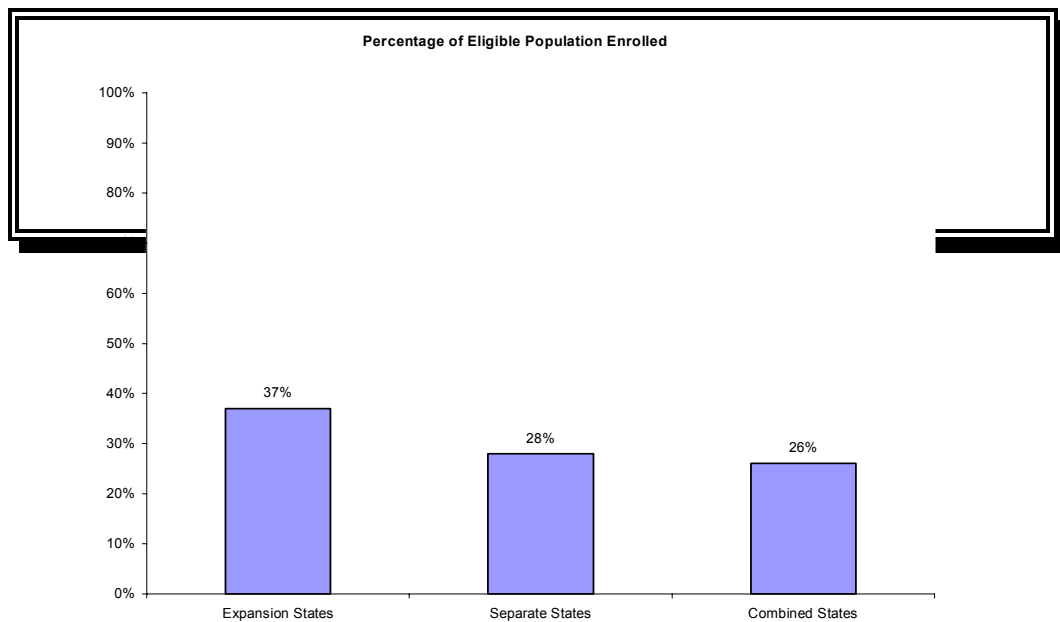
Figure 7



Source: Compiled by Program Review Staff Based Upon a Staff Survey of Other States

Figure 7 shows that states with other approaches to CHIP enrollment also fared better, on average, than Kentucky. The nine responding states with separate insurance programs for CHIP, that responded to our survey, averaged 28 percent of their eligible population enrolled. The 16 responding states that responded to our survey and had elected to expand Medicaid to provide CHIP coverage have enrolled approximately 37 percent of their eligible populations, on average. The ability to more rapidly enroll children through a Medicaid expansion can be attributed, at least in part, to the existing support structure for Medicaid. A new, separate insurance program infrastructure does not have to be created before children can be enrolled. New contracts do not have to be developed and negotiated; a new enrollment process is not required.

Figure 8



Source: Compiled by Program Review Staff based upon a staff survey of other states.

Program Review Staff discussed enrollment practices with some states that have enrolled more than the average number of children in their CHIP programs. In most of the cases, the states place a high priority on enrollment and, in some cases, they began enrolling before the federal funding became available. Officials in the high performing states told staff they have prioritized the enrollment of children. Indiana, for example, elected to expand Medicaid up to 150 percent of the federal poverty level for the first year of the program, while they worked on developing a full CHIP program. Officials within the Indiana Family and Social Services Administration told us their mandate was to go out and find children. They said their state could not turn its back on the available federal money tied to CHIP. Indiana officials also told us that there was an emphasis on linking CHIP and welfare reform, saying it is crucial for families attempting to become self-supporting to have health insurance for their children. Though Indiana plans to refine its CHIP program in the future, state officials told us that they felt it was necessary to enroll children even as they developed the rest of their program.

South Carolina has also expanded their Medicaid coverage to 150 percent of the federal poverty level. South Carolina began enrolling children in their CHIP Medicaid expansion on August 1, 1997 - two months before the federal funding for CHIP became available. Officials within the South Carolina Children's Health Program told us they used a Title IXX expansion to provide Medicaid benefits to children and did not begin claiming the enhanced CHIP matching funds until October 1, 1997. Ohio also elected to

provide coverage through a Medicaid expansion, and enrolled 85,257 children during calendar year 1998.

Kentucky's Plan One of Last Submitted, HCFA Raised Many Questions

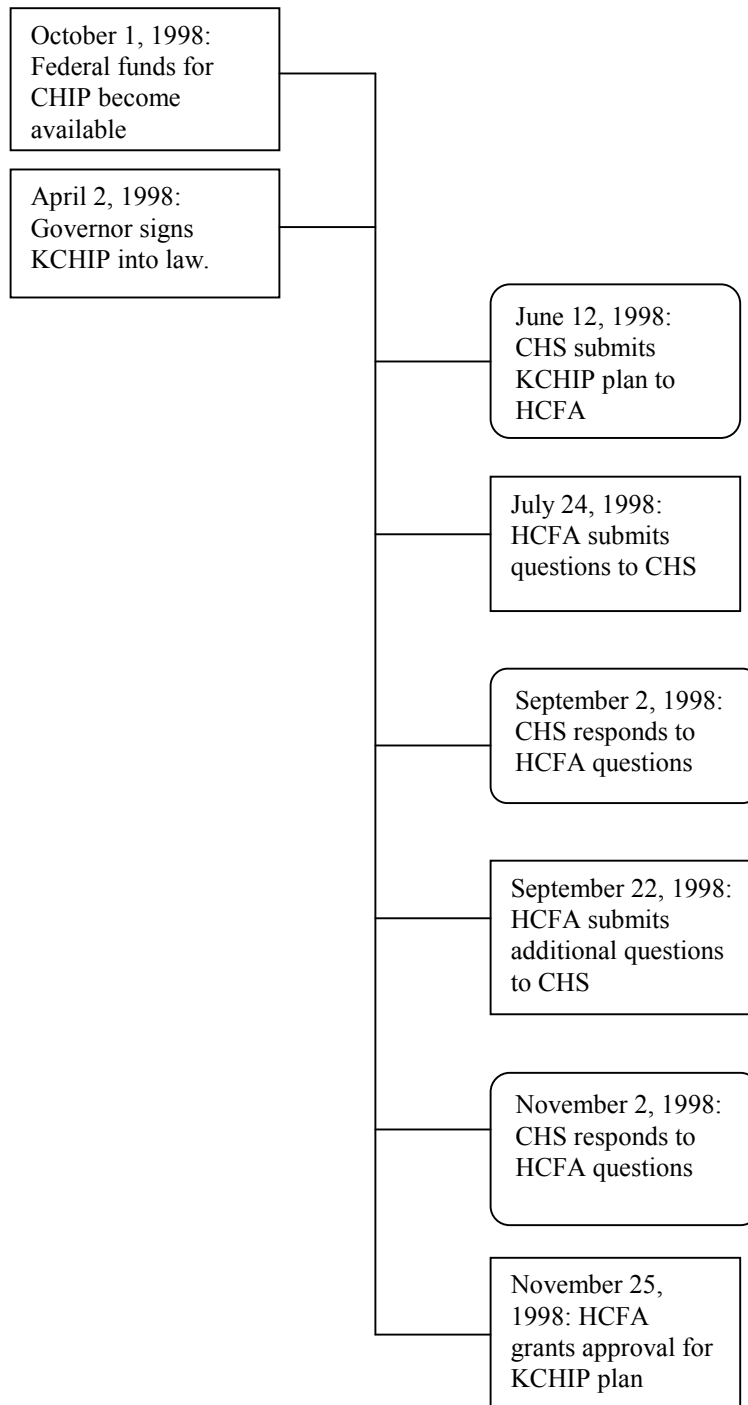
Questions about provisions in the KCHIP plan delayed HCFA's approval.

Delays have occurred throughout the development of the KCHIP program. Federal CHIP legislation passed on August 5, 1997, and Kentucky's CHIP program was not signed into law until April 2, 1998. Despite the elapsed time between the passage of federal and Kentucky CHIP legislation, Kentucky's CHIP plan was not completed and submitted to HCFA until July 12, 1998. Kentucky was the 41st state to submit its plan. Approval of Kentucky's plan was further delayed after the plan's submission to HCFA.

HCFA's concerns with Kentucky's plan included the proposed employer subsidy program that CHS eventually dropped from consideration. Other questions included clarifications on the amount of copays allowed and eligibility standards and methodology. It took 166 days for Kentucky's plan to be approved, approximately 34 days longer than the average approval time for other states. Nearly half the time spent on the approval process, 81 days, was spent with the approval process stopped while CHS developed answers to HCFA's questions. Kentucky's was the 46th CHIP plan approved by HCFA. The following Figure illustrates the KCHIP plan approval timeline.

FIGURE 9

KCHIP Plan Approval Timeline



Source: Compiled by Program Review Staff from data provided by CHS

In addition to delays in the federal application process, development of an administrative support structure for KCHIP has also been delayed. Although the Governor signed KCHIP legislation into law on April 2, 1998; the Cabinet for Health Services did not create a separate KCHIP administrative division until January 16, 1999. Even then the division was not fully staffed, with only four of the eight full-time positions in the division being filled. Cabinet officials told us that, prior to the creation of the division, the KCHIP program was directed from the Secretary's office and staffing needs were met by individuals from a variety of areas within the Cabinet on an as needed basis. They also explained that they are actively seeking staff to fill the vacant positions and expect to fill those positions soon.

Approach Chosen Excluded State Employees' Children

The exclusion of state employees' children is one of the unintended consequences of the KCHIP implementation strategy. Other states have also encountered this difficulty. According to the criteria applied by the Health Care Financing Administration (HCFA), states that contribute any amount toward health insurance coverage for the families of employees may not provide coverage to the children of state employees through a CHIP separate insurance program. HCFA officials told us that only two states, Mississippi and North Carolina, have been allowed to provide coverage to the children of state employees. HCFA officials told us these states provide no contributions to health coverage beyond the individual employee's benefits. In some Kentucky counties, for some health insurance plans, the amount the state contributes toward employees' health insurance coverage is more than the individual policy amount. HCFA has ruled that this extra amount may be interpreted as a contribution toward family coverage.

Only those state employees eligible for the KCHIP separate insurance program will be denied coverage. Those state employees who qualify for the KCHIP Medicaid expansion are not affected by the ruling. States that elected to provide CHIP coverage solely through a Medicaid expansion are not affected by this rule.

Will the children of state employees be eligible for KCHIP coverage? The Secretary of the Cabinet for Health Services has stated that Kentucky will not implement a CHIP program that does not include the children of state employees. Program Review staff asked HCFA officials if they were likely to reconsider their interpretation of the state employee ruling, HCFA responded that they have been as liberal as they can be in

interpreting the ruling, and indicated they are receiving pressure from Congress to avoid extending the state employee exemption any further. Until this impasse is resolved, the children of Kentucky state employees will not be eligible for the separate insurance portion of KCHIP.

Implementation Strategy Postpones Outreach and Enrollment

As a result of the two-tiered, combination strategy, CHS has intentionally delayed efforts to advertise and promote the KCHIP program. To date, a toll-free 800 number has been established. Letters have been sent to Medicaid providers across the state and CHS sent a postcard out to families receiving food stamps, advising them of the KCHIP program. CHS officials, however, have been reluctant to undertake more extensive outreach efforts until the separate insurance aspect of the KCHIP program is available. Cabinet officials indicated that they believe it would be counterproductive to advertise services which are not yet available to the majority of those eligible.

Delaying Kentucky's outreach program has cost us the opportunity to leverage our program with the efforts of others. For example, on February 23, 1999, a national advertising campaign for CHIP was launched. The campaign was announced by the President and First Lady. National television ads started on NBC and Univision (a national Spanish-language network) promoting a national 1-800 hotline number. This number will route incoming calls to the caller's state CHIP information number. To take advantage of the national campaign, radio advertisements will be run in the states in three phases. CHS elected not to participate in the first two phases of this campaign. Radio advertisements for KCHIP will not run until the final phase of the advertising campaign, April 12-May 2. Until then, Kentucky's hotline number will receive calls forwarded from the national number, but the state will not undertake a more active campaign.

HCFA officials have stressed the importance of outreach programs, noting that the CHIP enhanced match will apply to funding spent on outreach (up to the 10 percent of total CHIP expenditures are allowed for outreach and administration). As noted earlier, CHS has enrolled only 7 percent of the eligible children and has not yet begun its full outreach campaign. An RFP for a KCHIP advertising campaign was released March 8, 1999, with an anticipated contract award date of April 9, 1999. Cabinet officials told us that, until the private insurance portion of the KCHIP program is ready, it will be too early to begin an outreach campaign. Cabinet officials said they want to avoid the problem of people applying for the program, only to be told that it is not yet available.

Recommendation 2: Provide quarterly reports on KCHIP program status.

Based on the limited enrollment to date, provisions in 1998 legislation, and the lack of outreach efforts to date, we recommend that CHS provide quarterly reports to the legislature beginning in May 1999, detailing the following information:

- **The number of children enrolled in KCHIP.**
- **Total funds spent on KCHIP, to include the amount of federal funds spent to date by federal fiscal year.**
- **Efforts the Cabinet has undertaken to increase public knowledge of KCHIP and effectively market the program to the target population.**

Recommendation 3: Report on the eligibility of state employees' children.

Based upon HCFA's decision that Kentucky state employees' children are not eligible for inclusion in the separate insurance aspect of the KCHIP program, we recommend that CHS provide a report on their contingency plan to provide coverage to children of state employees who would otherwise be eligible for the KCHIP program

CHAPTER IV ADDITIONAL CONCERNS

Concerns have arisen over the administrative organizations CHS devised to implement the KCHIP program. CHS will use managed care organizations devoted to pediatric issues to implement KCHIP, and refers to these entities as “accountable pediatric organizations”. It is thought that APOs, due to their similarity to other managed care organizations, will not improve the financial outlook for local health departments throughout the state. The managed care nature of the APOs also raises some concerns about the potential for duplication with existing and planned Medicaid managed care partnerships and the cost effectiveness of the administrative structure for KCHIP. Finally, because of the limited provider network in many areas of the state, concerns have arisen over the ability of the proposed networks to provide equal care to all children enrolled in program.

Managed Care May Increase the Financial Difficulties of Local Health Departments

Program Review staff believes that the financial health of local health departments will not be improved, and may in fact be worsened by the KCHIP APO networks. Many local health departments are already experiencing financial difficulties as a result of the Medicaid managed care. CHS officials told us these financial problems have been brought about by a variety of factors including reduced Medicare reimbursement rates, stagnant state revenue, and an improving economy that reduces the number of Medicaid recipients. However, we found that the financial difficulties of local health departments have also been increased by the advent of Medicaid managed care.

CHS instituted Medicaid managed care as a way of reducing cost growth in traditional Medicaid. The managed care concept assigns a primary care physician for each enrollee and substitutes a set payment for each enrollee rather than paying a fee for each service provided to an enrollee. Providers are motivated to minimize the cost of care for each enrollee to maximize their profit margin. In traditional, fee-for-service Medicaid, health care providers were paid a fee based upon the services they performed. If they performed more services, they received more Medicaid dollars. Local health departments often received fees for Medicaid services that were higher than the cost of providing the service. The ‘profit’ in Medicaid services could then be used by the health departments to fund other services, such as providing healthcare for the indigent.

Staff examined the income of local health departments across the Commonwealth, comparing those within the Medicaid managed care partnerships to those still in a traditional fee-for-service region. From FY1996-97 to FY1997-98 Medicaid preventive care revenue decreased in the traditional fee-for-service areas by an average of 5.3 percent. In the Medicaid managed care regions, however, preventive care dollars decreased by 14.5 percent. This amounts to an average decrease of \$36,000 in Medicaid preventive services for non-managed care health department compared to an average decrease of \$147,800 in preventive care services for health departments in managed care districts. (see Appendix C for details by service region)

Since an APO functions as a managed care network, it is anticipated that this trend will continue under the KCHIP APO networks.. While the full role for local health departments within the APO networks has not yet been determined, trends observed under the Medicaid managed care partnerships will likely continue under the APO managed care networks. Though CHS intends that all public health departments will be included in the KCHIP networks, and anticipates that APOs will offer public health departments participation contracts, the role health departments will pay in KCHIP has not yet been negotiated. Patient care under KCHIP will be coordinated by the primary care physicians, who will provide most of the health care services to the KCHIP enrollees. APOs will be financially motivated to minimize any fees they pay to local health departments for services, in order to avoid reducing their profit margin.

Additionally, preventive services provided through the KCHIP program will not be assessed a copay. The capitated fee that is paid to the APOs for each enrollee includes an adjustment for copays and premiums the APOs are expected to collect. Without a copay for preventive services, providers will be less likely to schedule patients for preventive only visits. Preventive services will likely be provided when patients are already in their primary care physician's office for a service which will generate a copay. Visits to local health departments for preventive only services will be less likely and local health department revenues are likely to decline further.

APOs May Duplicate Medicaid Managed Care Administration

The APOs managed care network also creates the potential for duplication of administrative effort with the Medicaid managed care organizations. APOs are essentially managed care organizations that will focus on the unique needs of a pediatric population. APOs will be responsible for developing a provider network throughout the

geographic region they serve, assigning eligible children to a primary care provider to serve as that child's 'medical home.' These medical homes will coordinate the care of each participant and ensure that all needed services are provided. APOs will be paid a yet to be determined capitated rate for each child enrolled in their plan. The capitated rate will be negotiated during the contracting process, based upon actuarial analysis of the population and adjusted by an amount that APOs might be expected to receive in copays and premium contributions.

APOs are similar to the managed care concept the Cabinet is employing to provide Medicaid services in some areas of the state. The Cabinet is currently attempting to expand the Medicaid managed care concept to other regions of the state as it seeks to deploy the APO network for KCHIP. The dual managed care networks may represent a duplication of administrative function. Officials within the Cabinet stressed that APOs will be focused solely on pediatric care, and will structure their provider network to focus on pediatric needs. The Medicaid managed care partnerships, however, will also include the capabilities to provide services to their pediatric members. Additionally, the only two bids received for APOs in the recent RFP process were by the two entities that are already serving as the managed care providers for Medicaid Regions 3 and 5.

CHS officials also told us that, in many communities the same pediatricians and family care practitioners will serve both the Medicaid and the KCHIP populations. Cabinet officials said that there simply are not enough providers in Kentucky to form a large number of pediatric networks. Therefore, KCHIP and Medicaid managed care will have the same organizations serving the administrative function, and many of the same individuals serving as health care providers. Children in the same family may be enrolled in different programs solely because of their age. The cost effectiveness of this apparent duplication of administrative structure is also a concern, as well as the potential confusion to families that may have children enrolled in different programs solely because of their age.

Provider Network Limited

Staff also reviewed the number of pediatricians and family practice physicians across the state and found that the resources necessary for a pediatric network may not exist in all parts of the state. Five counties have neither a pediatrician nor a family care specialist. Thirteen counties have only a single pediatrician or family care specialist. In three of these counties the existing ratio of children to pediatric physician was roughly 3,500 to one. The following maps indicate the number of pediatric and family care

physicians by county, the number of children per physician by county, and the number of children under 18 with no insurance by county. Until the Cabinet has contracted with the APOs selected for the various regions of the state, it is difficult to determine whether adequate resources will be in place to support the state's KCHIP population. The KCHIP RFP requires that APOs meet certain minimum access standards. If the APO cannot meet the specified standards, it may operate by meeting community standards where there is a shortage of providers.

Based upon the critical need of the services to be provided, and the potential for administrative duplication noted earlier, monitoring of the APOs performance and measurement of health outcomes should be an ongoing process. The KCHIP RFP contains health benchmarks to be achieved within three years; however, these benchmarks often refer simply to the number of children who have received a particular service. It is important to also measure the outcomes resulting from services provided. APOs should be measured against the improvement in the health care of children, not simply upon the services provided.

Recommendation 4: Report on new roles and funding for public health departments.

Existing groups reviewing the financial status of health departments should develop a plan for identifying new roles and funding sources for health departments. This plan should be submitted to the legislature for review before the July 1, 1999 start-up date for the APO networks.

Recommendation 5: Develop a plan for monitoring and assessing of the APO networks.

CHS should develop and submit to the legislature a plan for monitoring the activities of the APO networks and assessing performance based upon quantifiable performance measures and health outcome measures contained in the RFP. Assessment of APO performance should then be carried out in accordance with the plan and reported to the legislature annually.

APPENDIX A
CHIP IMPLEMENTATION STRATEGIES BY STATE

CHIP Strategies By State

As noted earlier, there are three basic approaches to the CHIP program. States can either develop a separate insurance program, expand Medicaid, or develop a combination program through some form of Medicaid expansion as, well as a separate insurance program for those who do not qualify for the Medicaid expansion. Kentucky has elected to implement a combination CHIP program. The following table details the implementation strategy selected by other states and territories.

Separate Insurance Plans 14 States

Arizona
Colorado
Delaware
Georgia
Kansas
Montana
North Carolina
Nevada
New York
Oregon
Pennsylvania
Utah
Vermont
Virginia

Medicaid Expansions 28 States

Alaska
American Samoa
Arkansas
District of Columbia
Guam
Hawaii
Idaho
Illinois
Indiana
Iowa
Louisiana
Maryland
Minnesota
Missouri
Nebraska
New Mexico
North Dakota
Ohio
Oklahoma
Puerto Rico

Rhode Island
South Carolina
South Dakota
Tennessee
Texas
Virgin Islands
West Virginia
Wisconsin

Combination Plans

11 States

Alabama
California
Connecticut
Florida
Kentucky
Maine
Massachusetts
Michigan
Mississippi
New Hampshire
New Jersey

53 plans have been submitted as of 2/1/99, including those of Puerto Rico, The U.S. Virgin Islands, Guam, American Samoa and the District of Columbia. No plans had been submitted for the states of Washington or Wyoming, as of 2/1/99.

**APPENDIX B
OTHER STATE CHIP ENROLLMENTS
AND ELIGIBLE CHILDREN**

Data provided by states responding to our survey of enrollment is summarized below.

State	Enrollment	Eligible Pop.	Percentage	As of Date
Expansion States				
ARKANSAS	35,000	45,000	78%	1/31/99
D.C.	1,086	7,000	16%	2/28/99
IDAHO	2,997	5,000	60%	2/28/99
ILLINOIS	26,489	220,000	12%	3/1/99
IOWA	6,000	55,000	11%	1/31/99
LOUISIANA	8,694	28,350	31%	2/28/99
MARYLAND	41,114	109,000	38%	3/2/99
MISSOURI	30,660	68,476	45%	2/1/99
NEBRASKA	10,351	15,000	69%	2/1/99
OHIO	50,368	290,000	17%	1/31/99
OKLAHOMA	17,521	40,995	43%	9/30/98
RHODE ISLAND	3,085	17,000	18%	1/31/99
SOUTH CAROLINA	76,000	85,000	89%	2/28/99
SOUTH DAKOTA	1,665	9,000	19%	2/28/99
TEXAS	34,000	162,000	21%	11/30/98
W. VIRGINIA	497	1,700	29%	3/3/99
Average	21,595	72,408	37%	

Separate States				
ARIZONA	13,101	18,500	71%	2/23/99
COLORADO	12,000	70,000	17%	1/31/99
DELAWARE	521	10,500	5%	2/26/99
GEORGIA	8,670	120,000	7%	3/1/99
KANSAS	7,502	60,000	13%	3/1/99
MINNESOTA	51,363	101,000	51%	2/1/99
MONTANA	943	10,100	9%	1/1/99
NEW YORK	290,252	360,000	81%	2/1/99
NORTH CAROLINA	26,832	71,000	38%	2/26/99
OREGON	10,945	65,000	17%	2/26/98
UTAH	6,060	30,000	20%	3/5/99
VIRGINIA	4,418	72,000	6%	2/25/98
Average	36,051	82,342	28%	

Combined States

ALABAMA	25,000	50,000	50%	2/1/99
CALIFORNIA	71,000	1,100,000	6%	2/16/99
CONNECTICUT	11,007	89,700	12%	12/31/98
FLORIDA	69,726	189,500	37%	3/1/99
MAINE	5,400	13,000	42%	1/31/99
MASSACHUSETTS	14,083	135,000	10%	1/30/99
MICHIGAN	8,425	47,000	18%	2/16/99
MISSISSIPPI	5,000	15,000	33%	3/1/99
NEW JERSEY	26,000	100,000	26%	3/1/99
Average	26,182	193,244	26%	

* We attempted to contact all states following a combined implementation strategy, which, like Kentucky, use a medicaid expansion program in combination with a separate insurance program. New Hampshire, however, did not begin their CHIP program until January of 1999 and was unable to provide any information on their enrollment numbers to date.

APPENDIX C
ANALYSIS OF MEDICAID’S IMPACT
ON PUBLIC HEALTH DEPARTMENTS

Public Health Department Medicaid Financial Data

Department	FY1996-97 Preventive Services	FY1996-97 TOTAL Medicaid	FY1997-98 Preventive Services	FY1997-98 TOTAL Medicaid	Change in Total Medicaid	Change in Preventive	Dollar Change Preventive
Managed Care Regions							
103 ANDERSON	\$81,807	\$81,807	\$39,885	\$39,885	-51.25%	-51.25%	-\$41,922
109 BOURBON	\$96,505	\$96,505	\$128,469	\$128,469	33.12%	33.12%	\$31,964
111 BOYLE	\$69,645	\$69,645	\$105,301	\$105,301	51.20%	51.20%	\$35,656
115 BULLITT	\$155,901	\$155,901	\$107,522	\$107,522	-31.03%	-31.03%	-\$48,379
125 CLARK	\$318,419	\$763,186	\$91,884	\$566,752	-25.74%	-71.14%	-\$226,535
133 ESTILL	\$214,869	\$214,869	\$124,203	\$124,203	-42.20%	-42.20%	-\$90,666
134 FAYETTE	\$152,904	\$2,624,080	\$59,801	\$2,816,294	7.33%	-60.89%	-\$93,103
137 FRANKLIN	\$721,394	\$1,066,010	\$326,321	\$782,723	-26.57%	-54.77%	-\$395,073
156 JEFFERSON	\$989,712	\$1,146,545	\$627,577	\$996,671	-13.07%	-36.59%	-\$362,135
157 JESSAMINE	\$175,892	\$175,892	\$229,488	\$229,488	30.47%	30.47%	\$53,596
169 LINCOLN	\$77,040	\$77,040	\$80,090	\$80,090	3.96%	3.96%	\$3,050
176 MADISON	\$966,076	\$2,468,248	\$569,745	\$2,263,149	-8.31%	-41.02%	-\$396,331
187 MONTGOMERY	\$116,807.0	\$116,807	\$305,730	\$305,730	161.74%	161.74%	\$188,923
193 OLDHAM	\$92,838	\$92,838	\$60,707	\$60,707	-34.61%	-34.61%	-\$32,131
199 POWELL	\$274,947	\$274,947	\$232,618	\$232,618	-15.40%	-15.40%	-\$42,329
220 WOODFORD	\$135,126	\$135,126	\$110,600	\$110,600	-18.15%	-18.15%	-\$24,526
302 LINCOLN TRAIL	\$1,981,114	\$3,655,342	\$702,272	\$2,463,760	-32.60%	-64.55%	-\$1,278,842
305 NORTH CENTRAL	\$444,408	\$1,209,033	\$346,603	\$1,138,437	-5.84%	-22.01%	-\$97,805
306 WEST BLUEGRASS	\$322,148	\$322,148	\$291,195	\$291,195	-9.61%	-9.61%	-\$30,953
313 CUMBERLAND VALLEY	\$2,933,605	\$4,870,554	\$2,650,578	\$4,824,641	-0.94%	-9.65%	-\$283,027
315 WEDCO	\$398,657	\$986,500	\$366,058	\$1,056,660	7.11%	-8.18%	-\$32,599
THREE RIVERS	\$309,739	\$550,664	\$220,249	\$525,259	-4.61%	-28.89%	-\$89,490
					Av. Change in Total Medicaid	Av. Change in Preventive	Average Dollar Change

Fee For Service Regions					-1.14%	-14.52%	-\$147,848
102 ALLEN	\$99,982	\$328,079	\$100,249	\$342,027	4.25%	0.27%	\$267
112 BRACKEN	\$33,652	\$33,652	\$33,348	\$33,348	-0.90%	-0.90%	-\$304
113 BREATHITT	\$263,545	\$559,397	\$227,937	\$575,457	2.87%	-13.51%	-\$35,608
124 CHRISTIAN	\$875,216	\$875,216	\$801,911	\$801,911	-8.38%	-8.38%	-\$73,305
135 FLEMING	\$98,020	\$98,020	\$80,613	\$80,613	-17.76%	-17.76%	-\$17,407
136 FLOYD	\$595,789	\$1,067,298	\$574,014	\$1,139,087	6.73%	-3.65%	-\$21,775
145 GREENUP	\$189,677	\$189,677	\$124,950	\$124,950	-34.12%	-34.12%	-\$64,727
154 HOPKINS	\$305,886	\$305,886	\$313,847	\$313,847	2.60%	2.60%	\$7,961
158 JOHNSON	\$258,275	\$658,280	\$212,349	\$947,757	43.97%	-17.78%	-\$45,926
161 KNOX	\$270,578	\$745,467	336,094	\$905,872	21.52%	24.21%	\$65,516
163 LAUREL	\$299,344	\$299,344	\$265,983	\$265,983	-11.14%	-11.14%	-\$33,361
168 LEWIS	\$50,504	\$50,504	\$47,776	\$47,776	-5.40%	-5.40%	-\$2,728
177 MAGOFFIN	\$193,534	\$193,534	\$244,678	\$244,678	26.43%	26.43%	\$51,144
179 MARSHALL	\$284,277	\$284,277	\$229,829	\$229,829	-19.15%	-19.15%	-\$54,448
180 MARTIN	\$231,617	\$231,617	\$192,121	\$192,121	-17.05%	-17.05%	-\$39,496
186 MONROE	\$48,315	\$48,315	\$47,596	\$47,596	-1.49%	-1.49%	-\$719
189 MUHLENBERG	\$387,453	\$387,453	\$438,981	\$438,981	13.30%	13.30%	\$51,528
198 PIKE	\$371,529	\$371,529	\$417,028	\$417,028	12.25%	12.25%	\$45,499
210 TODD	\$135,602	\$135,602	\$111,263	\$111,263	-17.95%	-17.95%	-\$24,339
218 WHITLEY	\$893,754	\$1,440,161	\$960,438	\$1,713,340	18.97%	7.46%	\$66,684
301 FIVCO	\$923,156	\$923,156	\$712,802	\$712,802	-22.79%	-22.79%	-\$210,354
303 BARREN RIVER	\$718,456	\$3,690,834	\$734,311	\$3,745,231	1.47%	2.21%	\$15,855
304 PURCHASE	\$1,740,097	\$3,181,134	\$1,709,083	\$3,315,640	4.23%	-1.78%	-\$31,014
309 LAKE CUMBERLAND	\$1,975,431	\$1,975,431	\$1,775,877	\$1,775,877	-10.10%	-10.10%	-\$199,554
310 NORTHERN KENTUCKY	\$849,458	\$849,458	\$674,554	\$674,554	-20.59%	-20.59%	-\$174,904
311 LITTLE SANDY	\$465,164	\$465,164	\$406,791	\$406,791	-12.55%	-12.55%	-\$58,373
312 KENTUCKY RIVER	\$2,660,348	\$5,502,469	\$2,142,119	\$5,301,832	-3.65%	-19.48%	-\$518,229
314 GREEN RIVER	\$1,776,802	\$3,569,362	\$2,044,130	\$3,845,992	7.75%	15.05%	\$267,328
316 GATEWAY	\$794,553	\$794,553	\$712,953	\$712,953	-10.27%	-10.27%	-\$81,600
318 PENNYRILE	\$405,028	\$405,028	\$422,803	\$422,803	4.39%	4.39%	\$17,775
321 BUFFALO TRACE	\$337,572	\$337,572	\$314,473	\$314,473	-6.84%	-6.84%	-\$23,099
					Av. Change in	Av. Change in	Average
					Total Medicaid	Preventive	\$36,184
					-1.59%	-5.31%	